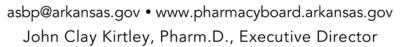


## Arkansas State Board of Pharmacy

322 South Main Street, Suite 600 Little Rock, AR 72201 P: 501.682.0190 F: 501.682.0195





## Application for a Permit to Operate as a Charitable Clinic in Arkansas PART I: GENERAL INFORMATION

Clinic Name:								
Employer Ident	ification	Numbe	r:					
			Physical	Address of Applicant:				
Street:			,					
City:			State: Zip:					
Telephone Number:				Fax Number:				
Website:				- ax rambon				
woode.	(Comp	olete this		ailing Address: if different from the physical address above	e.)			
Street or PO Bo	ox:							
City:			Sta	ate: Zip:	Zip:			
Person with whom the Board of Pharmacy may communicate regarding this application:								
Name: Position:								
Telephone:			Emai					
тетерионе.			Liliai					
Type of Charitable Clinic:  ☐ Clinic of the Arkansas Department of Health ☐ Other Charitable Clinic  Individual or Group Responsible for the Clinic:								
			Hou	urs of Operation:				
(Check all that apply):		ply):	Day	Hours (Express in terms of a.m. and p.m.)	Total Hours / Day			
□ 1 <sup>st</sup> □ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Sunday					
□ 1 <sup>st</sup> □ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Monday					
□ 1 <sup>st</sup> □ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	□ 4 <sup>th</sup>	Tuesday					
☐ 1 <sup>st</sup> ☐ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Wednesday					
□ 1 <sup>st</sup> □ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Thursday					
☐ 1 <sup>st</sup> ☐ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Friday					
□ 1 <sup>st</sup> □ 2 <sup>nd</sup>	☐ 3 <sup>rd</sup>	☐ 4 <sup>th</sup>	Saturday					
				Total Number of Hours Per Week				
OR OFFICE USE	ONI Y-							

License Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_

## **PART II: PERSONNEL**

List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this facility. You may attach additional sheets if needed. **YOU MUST NAME A PHARMACIST IN CHARGE.** 

Name	License #	Hours/Week	Degree						
Pharmacist in Charge:									
Other Pharmacists:									
Pharmacy Technicians:									
	<u> </u>								
PART III. OPERATIONS									
Please respond to the following statements/questions. You can attach a separate sheet if you need more space.									
Please provide a general description of the medications and products that you plan to dispense. You may attach a separate sheet if necessary.									
Do you plan to charge clinic patients a	ny type of fee, or ask	for donations?	☐ YES ☐ NO						
If <b>Yes</b> , please explain.	, ,,								
ii 100, piodos explaini.									
	rill comply with regula	ation 09-00-0001	<ul> <li>patient counseling, patient profile, drug</li> </ul>						
use evaluation.									
How will your phormony and the phorn	aciat in charge analy	ro that nations of	onfidentiality in maintained?						
How will your pharmacy and the pharmacist in charge ensure that patient confidentiality is maintained?									
Describe the computer hardware and s	software that will be u	sed in the pharr	macy.						

How does your pharmacy ensure a	valid patient / physician relationship?	
Do you process prescriptions for ins	•	☐ YES ☐ NO
If <b>Yes</b> , please name those com	ipanies.	
Are you are involved in any aspect	of telemedicine?	☐ YES ☐ NO
If <b>Yes</b> , please describe.		
	PART IV: DOCUMENTATION	
Attach copies of the following docume	ents to this application, or an explanation of why t	these documents are not included:
<ul> <li>A copy of the charitable clinic approved by the Board.</li> </ul>	pharmacy's Policies and Procedures. These Pol	licies and Procedures must be
B. A copy of the floor plan.		
C. A copy of the formulary.		
D. A copy of the non-profit or org	ganizational certificate, if applicable.	
	PART V: CERTIFICATION	
Please read carefully and sign below.		
	made herein and on the attached forms are true a d to the practice of pharmacy in Arkansas will be d effect.	
Arkansas. (They are available online a	to locate the statutes and regulations related to the at the Arkansas State Board of Pharmacy websit 7-92-101 et seq and Regulations 1 through 12.)	
the instructions and terms as set forth information given in this application is State Board of Pharmacy to review file ecords, administrative records, and co provided herein. This application and	solemnly swear or affirm that I am of good moral in this application form, that I have personally continue, correct and complete to the best of my known espertaining to this application and related document documents to confirm the accuracy and complete shall act as authorization for entities in the the Arkansas State Board of Pharmacy.	ompleted this form, that the owledge. I authorize the Arkansas ments, and all law enforcement on the information
Signature of Pharmacist in Charge:	:	
Print the name of the Pharmacist in	n Charge:	
Pharmacist License #:	Date:	